# CHILD AND ADULT CARE FOOD PROGRAM

Montana CACFP

## F/R Proprietary Center Claim for Reimbursement

Claims are due on or before the ***10th*** of each month. ***Claims not postmarked and/or received within 60 days of the claim month will not be paid*** **[REF: 7 CFR 226.10(e)]** without FNS approval for a one-time exception.

| | |
|---|---|
| ____ Number of Facilities<br>____ Number of Days CACFP Meals Were Served<br>____ Total Monthly Attendance<br>____ Average Daily Attendance<br>____ Licensed Capacity | Current Month Enrollment:<br>____ Free<br>____ Reduced<br>____ Paid<br>____ Total |

| | |
|---|---|
| Total CACFP Meals Served to Enrolled Children:<br>_____ Breakfast<br>_____ Lunch<br>_____ Supper<br>_____ Supplement/snack | Proprietary F/R Certification:<br>The institution certifies that at least 25% of enrolled children, or 25% of licensed capacity, **whichever is less,** are classified as Free or Reduced, and meet eligibility requirements for this reporting month.<br>Divide # of Free & Reduced Children by Total Enrollment **or** divide # of Free & Reduced Children by Licensed Capacity to determine eligibility. See the reverse side for further instruction.<br>Total Enrollment: _____<br>Licensed Capacity: _____<br># of F/R Children: _____<br>_____<br>Center Director Signature |

I certify that to the best of my knowledge and belief, this claim is true and correct, records are available to support it, it is in accordance with an existing agreement, and payment has not been received. I understand that this information is being given in receipt of federal funds and that deliberate misrepresentation of the information may subject me to prosecution under applicable state or federal laws.

Signature _____ Date _____

Title _____ Phone _____

**Child & Adult Care Food Program**
**Department of Public Health & Human Services**
**111 N. Jackson St. 5th Floor, PO Box 202925**
**Helena, MT 59620-2925**
**Toll Free 888-307-9333**

Institution: _____

Address: _____ Provider #: _____

For Month of _____ 20____

**White: State Agency** **Pink: Center**

## TOTAL MONTHLY ATTENDANCE

Record the total number of children in attendance daily. This should include every child who attended during the day.

Each month, add the totals for each day's attendance. This is the total Monthly attendance.

## Calculate the AVERAGE DAILY ATTENDANCE

Divide the Total Monthly Attendance by the Number of Days the Center Operated. Round this number to the nearest whole number.

### FR/P CERTIFICATION

1. Add Free and Reduced participants;
2. Compare the enrollment and licensed capacity, selecting the lesser number; then,
3. Divide F/R Participants by the lesser of enrollment or licensed capacity to determine if your center has met the 25% minimum and are eligible to submit a claim. The answer should be .25 or more.
4. **Example #1**:

| | |
|---|---|
| Total Enrollment: | 36 |
| Licensed Capacity: | 30 ← Capacity is less than Enrollment. |
| # Of F/R Children: | 7 |

```
   .233
30) 7.0
  - 60
    100
   - 90
     10
```

**.233**

Move the decimal two places to the right to convert to a percentage.

23.3% is less than 25%; this center **may not** claim.

5. **Example #2:**

| | |
|---|---|
| Total Enrollment: | 46 |
| Licensed Capacity: | 35 ← Capacity is less than Enrollment. |
| # Of F/R Children: | 12 |

```
   .342
35) 12.0
  - 105
    150
   - 140
     100
      -70
```

**.342**

Move the decimal two places to the right to convert to a percentage.

34.2% is more than 25%; this center **may** claim.